Listening Session: Public Health/Healthcare Industry

The Workplace Partnership Group conducted a listening session on Thursday, January 28, 2016, to engage employees and employers within the Public Health and Healthcare industry. The session was conducted at the offices of Allina Commons, Pettingill Hall, 2925 Chicago Ave S, beginning at 2:07 p.m. A select number of panelists representing both employees and employers were invited to provide their perspectives in response to a pre-arranged set of questions related to policy issues concerned with earned sick time and paid time-off (PTO). The following is a summary of feedback from participants in this listening session.

Liz Doyle, Chair of the Workplace Partnership Group, explained the context for the charge given to the Workplace Partnership Group in considering policy elements that might be considered as part of an overall municipal policy on earned sick time and/or paid time-off, including any regional and cross-jurisdictional implications of such policy. To help structure its approach to the myriad of issues involved in a potential municipal policy mandate, the Workplace Partnership Group was exploring aspects of policy elements in three major categories: (1) elements that could improve public health, generally; (2) elements that would improve labor conditions, specifically targeting employee health in the workplace; and (3) improving the business climate in Minneapolis to attract and retain the best workforce possible. Within those three major categories, some of the primary questions focused on how broadly the coverage of a municipal mandate should be; how any benefit would be accrued and applied; and the mechanisms around administration, monitoring, and enforcement, as well as safeguards to avoid abuses of the policy by both employees and employers. These were reflected in a "decision pathway" chart that visually depicted the scope of work being considered; see attached chart for details. A final report of policy recommendations was due to the Mayor and City Council by February 24, 2016.

Gretchen Musicant, Commissioner of Health for the City of Minneapolis, presented information about the public health consequences of illness, citing case studies related to specific diseases, and the potential impact to workers lacking access to paid sick time. She noted that disparities were largely the result of policy decisions that systematically disadvantaged certain populations; in particular, low-income workers and communities of color. Thus, the greatest potential for meaningful change to address these public health disparities was through policy initiatives targeting these populations. See attached PowerPoint presentation for details.

PANEL FEEDBACK

[*The following questions established the broad framework within which participants were invited to provide feedback.*]

Question #1. How broadly or narrowly should the City of Minneapolis consider coverage to effectively address the public health and equity concerns associated with policies related to earned sick time and paid time-off?

Question #2. How should paid sick time and/or paid time-off be used? What are your experiences in offering this kind of coverage, or in using paid sick time?

Question #3. How should paid sick time and/or paid time-off be earned? Should it vary by hours worked, business sector, revenue, number of employees? Should it be capped?

Question #4. What, if any, measures should be considered to ensure workers are not penalized for using paid sick time, and to ensure that employers are not subject to undue hardship or abuse of such policies?

One participant, a human resources professional for a large hospital, said the 24/7 nature of the healthcare industry created some unique workplace situations, and these unique needs should be accommodated in a municipal sick leave policy. She explained that very often the hospital was not the primary employer for much of its workforce, noting the casual, temporary, and agency workers who filled the ranks of healthcare positions, often working for multiple employers. Not being the primary employer for many of these workers, it would create significant financial burdens if the hospitals were required to provide paid sick leave or PTO for these types of workers. She noted that her organization offered PTO and paid sick time to benefit-eligible employees and were committed to supporting a healthy workplace for all its workers. However, again, she expressed concern that a uniform policy could result in unintended, negative consequences; in particular, she noted that a policy that was geographically limited to Minneapolis could create uneven workplace policies—often perceived as employee incentives—between businesses and organizations with multiple facilities located throughout the metropolitan region.

One worker explained she had worked many years as a benefit-eligible employee but had been working the past 4 years as a casual employee. She described the difficulty of that type of on-call work arrangement, in which she frequently had little advanced notice of scheduled work hours, sometimes as little as 24 hours, and she had no benefits, including no paid sick time or PTO. She also drew connections between access to paid sick time with access to health insurance, which she said was equally if not more important to low-wage earners whose lives were often in a precarious position when forced to choose between working while sick or potentially losing your job, and those your income, if you chose instead to stay home from work to tend to your own health needs. She noted that she paid up to $600 per month for COBRA in order to maintain her insurance coverages after losing her full-time, benefits-eligible position. Working sick in front-line, customer-facing positions included the potential to expose those customers, clients, or patients to the spread of illness. So, not only did she believe access to paid sick time was important, but it was closely tied to the need for access to health insurance.

One participant described how, in operating a 24/7 housing service with facilities serving adults and children, her organization relied heavily on part-time workers, which necessitated flexible scheduling approaches to ensure all shifts were adequately covered. She said she was concerned that a municipal policy might be an incentive to abuse by employees who might use paid sick time for purposes other than health-related needs of themselves or their dependent family members. She said she very much supported the concept; but still had concerns about the potential for abuse, and the negative consequences to employers who had no choice but to fill shifts to serve clients. She also noted there was a difference in responding to absences caused by "casual illness" versus major epidemics, and the threat of wide exposure to contagion. She said a uniform policy would treat all situations the same, whereas a more nuanced approach—one that respected the need of employers to make workplace choices unique to their own environments—was what was needed. She said a municipal mandate would have negative impacts to budgets and funding streams.

One participant, whose agency employed more than 10,000 workers in Minneapolis, expressed his support for previous statements, adding that he disagreed with a broad, one-size-fits-all policy approach which he believed would create not just burdensome administrative requirements, but would also negatively impact Minneapolis-based employers who would be put at a competitive disadvantage with other agencies in the regional metropolitan area. He said that employees who transition frequently between facilities—those inside and outside Minneapolis—further complicated the process of documenting, monitoring, and reporting which workers were eligible to accrue paid sick leave (or PTO) while working in Minneapolis, how much, how those accruals were to be managed, and what access was available and under what conditions, separate and apart from other workers—potentially employed by the same organization—who did not work within the City of Minneapolis. He went on to say that another concern was that an uneven policy mandate would make predictability in scheduling workers more difficult. He also pointed to the unanswered question of whether a municipal policy mandated by the City of Minneapolis would apply to other government agencies—for example, workers employed by Hennepin County, the University of Minnesota, or the Minneapolis Public Schools—which sometimes acted as competitors to those in the public, healthcare, and nonprofit sectors.

Another participant, a nurse at the University of Minnesota Medical Center, said universal access to paid sick time was a common-sense policy that contributed to good public health outcomes. She told her of experiences in the healthcare industry working with elderly, newborn, and immunocompromised individuals; she noted that every year, many people from those groups died every year from complications caused by the flu. Despite public health messaging to the contrary, she said it was too common for healthcare workers to be on the job while sick simply because they lacked access to paid sick time. She said having sick employees exposed to patients in the healthcare industry was dangerous. That was incongruous with declared positions of supporting workers having access to paid sick time or PTO. She appreciated the presentation offered by Commissioner Musicant in setting the stage for the discussion, and agreed that stronger public health policies that protected all workers were necessary; she disagreed with the description of such policies as "benefits" of a job, rather, she said they were essential to the goals of community health. Another nurse participating on the panel concurred, but acknowledged that a policy could present challenges to employers in terms of staffing and scheduling, operations, and fiscal impacts, including the potential for added labor costs. Still she said, in the scale of things, she believed that people's health and healthcare needs should trump profits. She noted that the City of St. Paul had recently announced it, too, was considering the potential for a municipal sick time policy, similar to the City of Minneapolis; thus, if both of the state's largest municipalities led on this issue, she believed it might lessen some of the concerns about marketplace competition, administrative burdens, and increased labor costs. And, she added, access to earned safe time for victims of domestic violence was equally essential as paid sick time, and she encouraged consideration of use of any paid sick time or PTO to include the coverage for safe time.

One employee panelist, adding to the idea that access to paid sick time was an urgent need, said that as a union member his benefits had been negotiated to ensure workers' rights were considered, and those negotiated agreements provided him a guarantee that was a sort of security policy for his health and the health needs of his family. He said the city needed to carefully consider any policy that might unintentionally result in a negative consequence of undoing negotiated agreements and bargaining rights that supported workers. He said employers and employees needed to work together, not fighting each other, since a healthy workforce was a more productive workforce, contributing to a positive workplace that ultimately benefitted the strategic advantages of the employer. Other employee representatives agreed that negotiated agreements that included access to paid sick time and/or PTO shouldn't be disrupted by any policy initiative pursued by the City of Minneapolis. Some suggested that if the goal was to ensure all workers had access to paid sick time/PTO to address healthcare needs and the outcome of a healthier community, then more thought needed to be given to how to expand access to all workers, not limiting such access to workers in full-time positions, particularly when those most in need were most frequently those workers who didn't have full-time employment status.

Another employer panelist said her employees had access to paid sick time, and she totally supported the concept of universal access to paid sick time, at least in theory. However, from a practical perspective, she had serious concerns about the implementation of any such policy and the financial burdens associated with increasing costs tied to labor. She said her agency's funding was totally determined and driven by the State of Minnesota, and she had no discretion in how to use those funding streams because it was heavily regulated and tightly prescribed by the State Legislature. She reiterated concerns about the potential of creating unequal treatment for employees within the same agency, based on employment status, among other factors.

Framing this proposal as a "benefit" of employment was not helpful if, as indicated, the fundamental drivers were healthier communities where all workers had an equal access to paid sick time/PTO. If the purpose was to keep the entire community healthier and, by extension, safer, and if the equity goals articulated by the City of Minneapolis were part of that, then some of the employee panelists said rather than referring to access policies as "benefits," they should be framed as a guarantee of employment offered to all workers in Minneapolis. Vacation hours were more appropriately termed "benefits" of employment; but sick time hours were a real need for all workers, tied to health and wellness, not time away for vacation or other purposes. One employee panelist said that workers having to choose between working and, thereby, keeping their

jobs—often low-paying, part-time positions—versus missing work in order to take care of themselves of their families, then the premise of a healthier, safer, more equitable community was not going to be fully realized.

A nurse on the panel noted that her negotiated employment contract ensured access to paid time off and sick leave, which was accrued based on the number of hours worked, regardless of employment status (full-time versus part-time), and began with the first day of employment. By tying the accruals to hours actually worked, the amount of benefit is partly determined by the worker: the more hours worked, the more accrued sick time/PTO.

An employer representative spoke to the need of providing flexibility in a policy to address the use of casual, on-call, and temporary workers. He said many workers in these positions appreciated the added flexibility that such jobs afforded, most of whom, he said, held other jobs as a source of "primary employment," where benefits—including paid sick time—might be accrued. A casual worker at one hospital might be picking up additional hours to increase income while working full-time (or three-quarter time) at another hospital or clinic where they received benefits; this was not uncommon in the healthcare industry. As employers who benefit from this casual workforce, he said they attempted to provide attractive environments, including working with employees to offer schedules that met their needs. He also reiterated the administrative complexity of attempting a one-size-fits-all policy in Minneapolis, especially when a large percentage of the casual, on-call workforce lived outside Minneapolis and frequently moved day-to-day between facilities that were both inside Minneapolis and outside in neighboring suburbs. Tracking the hours worked in Minneapolis, determining the total benefits accruals, monitoring and reporting accruals and usages, monitoring enforcement, and reporting for compliance purposes, especially for an on-call workforce, would be an administrative nightmare. Another employer representative on the panel concurred, adding that her organization had employees scattered throughout the metropolitan area, including Plymouth and Golden Valley, and limiting benefits to workers in Minneapolis created an unfair work environment. A better approach would be a metro-regional initiative that provided broader access under uniform policies across the seven-county region. More employer panelists supported this issue: if equity was part of the concern, then a policy limited only to Minneapolis actually negatively impacted equity goals within organizations that operated both inside and outside the city, since parts of their workforce would see a benefit that other workers would not receive. Employers felt it was odd and uneven-handed to implement worker benefits policies based solely on geographic location, especially when the work performed and the service provided across the business—despite physical location—was essentially the same. Ironically, that seemed to be the opposite of equity, in their opinion.

To this point on equity, some countered that employers had the option to extend paid sick time/PTO benefits to the entire workforce, even those outside of Minneapolis. That was a business decision, which might be the result of an initial requirement in the City of Minneapolis. Employers participating in the discussion understood that, but argued that a mandate in one community shouldn't drive business decisions for organizations operated across multiple jurisdictions, especially when other jurisdictions—following the lead by Minneapolis—might develop different policies. Thus, a broader, regional approach was essential so that contrary, competing policies were not enacted in different jurisdictions, which would only defeat the entire goal of ensuring universal access to paid sick time for workers. The fear, they explained, was what might happen if St. Paul, for example, determined to offer workers in that city accruals based on a different formula from what was enacted in Minneapolis; or, what would happen if Bloomington were to restrict access to paid sick time to only full-time workers, but Minneapolis required access to all workers, whether full-time, part-time, or on-call. Having local governments pursue such policies was a riskier proposition to businesses because of the potential for differences between the actual policy requirements. A state or at least regional approach provided better assurances of uniform requirements.

Employee panelists expressed the opinion that accruals should be based on the number of hours actually worked, regardless of employment status; whether full-time, part-time, on-call, or other. In terms of use, they believed limits or restrictions created disincentives since workers would still potentially be forced to choose how and when they might use their accrued sick time hours. For example, a nurse mentioned that

even though she was fortunate to accrue paid sick time hours, she did not have access to paid maternity time off from work; therefore, she could use her accrued sick time, even though being away from work to give birth and care for a newborn child was not truly "sick time" use. Moreover, if she used up her accrued sick hours as a sort of paid maternity leave, then she had no guarantee if and when she actually got sick and needed that time for her own health and wellbeing. Thus, she was again presented with a false choice: take time off without pay to care for her newborn child, or take a gamble and use sick time to offset the leave for maternity and hope that she doesn't get sick later.

Another worker said clear policies around how paid time is used should contemplate enforcement and possible disciplinary actions. Employers should be limited to taking punitive action based on the patterns of absence, not the actual number of absences from work because of illness. She also said having accruals based on a set number of hours or days, when that benefit is capped, then it creates in the worker a mindset of "use-it-or-lose-it" which can, as an unintended consequence, lead to potential abuse since workers don't want to feel that they are "losing" a benefit or having a benefit taken from them. She also said policies that required documentation to verify an illness were mostly unnecessary, except potentially in the case of extreme or serious illness or extended absence from work; requiring a doctor's note was a burden on employees who had to take time to visit the doctor and incur a co-pay for the visit, which was a further financial burden to the worker. She also suggested that a universal policy might need to contemplate different accrual rates and possibly caps depending on the work environment; those workers in industries or fields that were more exposed to potential sickness/illness and the possible spread of disease—like the healthcare industry, as one example—might need to accrue paid sick time or PTO at a higher rate than a worker in a traditional office environment.

Another worker noted that in his workplace, employees had the option to exchange or share accrued hours with co-workers; thus, if someone needed additional paid time off from work, employees could donate their accrued hours to that worker. He said this was an added benefit that provided more flexibility to workers, and should be incorporated in any policy considered by the city. Another panelist said her organization provided its workers with both vacation time and "all-purpose time," similar to PTO, which was accrued based on the total number of compensated hours worked by the employee. All-purpose time could be used at the discretion of the employee, including for a mental-health day.

Another employer representative on the panel said his organization provided benefits based on the number of compensated hour worked, which he believed was both the most practical approach as well as the most universal in terms of existing policies in the majority of business sectors/industries already in place. Being consistent with those other practices, then, made it a more attractive option for how accruals should be calculated in a universal municipal policy since it presented the least-potential disruption. He added that he preferred to see a policy that aimed at PTO rather than separate sick-time leave benefits. Most organizations had transitioned away from separate leave policies, which required additional administrative work; a universal PTO policy reduced the administrative requirements on employers and gave maximum flexibility to employees, who could use their accrued hours as they needed at their discretion. From his experience, he said he'd seen less employee abuse since the transition to a uniform PTO policy, which he attributed to the greater flexibility and freedom given to employees to use as they and their families needed. He said previously they experienced higher incidents of employee abuse where sick time, vacation time, and other paid leave times were offered.

To the extent Minneapolis pursued a universal sick-time or PTO policy, employer panelists emphasized the need to provide adequate protections for employers against employee abuse. Many said that, while not in the business of punishing employees, they needed some way to address potential policy violations or abuses so that they can manage their workforce, especially when patterns of abuse are discovered. Not only was it unfair to employers, it was equally unfair to other good employees who followed the rules and used their paid leave benefits only for the purposes for which they are intended; thus, if only a sick-time policy were enacted, it would not be appropriate for an employee to claim sick-time access for any purpose other than sick time needs. This underscored the preference for a PTO policy, rather than a more narrow policy focused

exclusively on paid sick time. To that end, one employer suggested that a municipal policy might be modeled on the existing federal Family Medical Leave Act (FMLA), which addressed job protections or security while tending to family medical needs; that could be adapted locally to address individual and/or family health and wellness needs while providing some security over the position.

One nurse on the panel said her employment contract gave clear guidance on her benefits, which she appreciated, since it limited the potential for any misinterpretation by the employer or by employees and was fairly and equitably administered to everyone covered under the terms of that bargained agreement. Under that agreement, she earned 8 hours of sick time for every 173.3 hours worked, which could be rolled over year-to-year, with a cap at a total of 720 hours accrued. Employees could not be penalized for the number of sick days used, but the employer or the employee could request a conference to discuss the amount of sick time used, if abuse was suspected. The employer could request reasonable evidence of the need for sick time use, such as a doctor's note, but the policy did not mandate documented verification of sick time on the day of the call-in.

Responding to clarifying questions, one panelist explained the use of casual employees in the hospital environment, indicating that the practice was for a casual employee to make themselves available for at least 2 days per month, and then for any additional hours/days required; a casual employee could refuse additional hours/days beyond the mandatory 2 days per month, and could claim access to paid sick time, if that benefit was provided, in order to offset additional hours/days each month. From an employer perspective, the use of casual workers helped to ensure shifts were adequately covered. However, it can escalate quickly when a full-time employee claims sick time, and the casual employee called to cover that shift also claims sick time, which necessitates a third worker to cover the shift; essentially, an employer could be paying 3 or more times to cover a single shift. So, there were scheduling complexities to cover shifts as well as the labor impacts to actually ensure shifts were covered. More so than the mere administrative burden, employers and employees pointed toward the larger public health implications for patient care when a health care provider had to call down to the lowest worker to cover a shift and that particular worker, who may lack access to sick time benefits, might be coming into contact with patients while sick or potentially aiding in the spread of illness or disease. The burnout among employees who are challenged to make tough decisions about whether to work or attend to their health and wellbeing was another factor to consider. Some employees—unsure of how to access sick time or scared of using sick time hours for family needs—therefore not only came to work sick but also, in response to other workplace realities, often were made to work overtime or cover double-shifts, etc., and that has a negative impact not just on the employee and the workforce, but also on patient care.

Some agencies are subject to strict funding and budget regulations enforced by the state; they have no discretion about how much of their funding streams may be allocated toward labor, because there are strict requirements—and restrictions—about how those public dollars may be allocated and used. Thus, a uniform municipal policy could have negative consequences by requiring a state-funded agency to reallocate within limited labor dollars, short-changing some workers over others, due to existing labor contracts or other factors. For the state-dictated rate methodology, it's usually a percentage basis that prescribes an average wage and percentage of benefits. Up to 75% of wages or benefits are dictated by the State Legislature; the remainder goes to administrative and operational costs. As a public agency, those additional costs—which might be associated with increased labor costs for a municipal sick-time mandate—cannot be passed along to the client. Essentially, the municipal policy becomes an unfunded mandate imposed by the City of Minneapolis.

From the floor, an attendee said that those most at-risk in Minneapolis were the low-wage earners, often those in part-time (or less) positions, and frequently represented communities of color, particularly immigrants who often had limited English proficiency. As a result of these realities, there were additional barriers to these workers to be able to access benefits like paid sick time. Yet, they also had healthcare concerns affecting themselves and their families; having the ability to attend to those healthcare needs was not a factor that should be tied to whether or not they had a job, whether that job was considered full-time

or part-time (or other status), and how many hours were worked. That reflected the premise that access to paid sick leave was a benefit of employment, a benefit reserved for some and denied to others. Some argued that these realities underpinned why the City of Minneapolis was pursuing a paid leave policy; because of recent studies showing the significant disparities between white workers and workers of color, between some types of workers and others, the need to eliminate references to paid sick-time leave as a "benefit" of employment missed the crucial issue—disparities had negative impacts on the entire community, resulted in greater risks to the general health of the entire community, and failed to incentivize a better work environment for all workers (and businesses) in Minneapolis. Some in attendance encouraged a more humanistic approach to consideration of a policy mandate; the most vulnerable and at-risk communities often lacked a voice in policy discussions, and it was critical that the city recognize this and ensure that the voices of those workers were not lost in the larger community dialogue.